Maricopa County
Pharmacy Benefit Plan

Administered Through
Walgreens Health Initiatives (WHI)

Effective January 1, 2005

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SUMMARY PLAN DOCUMENT

MARICOPA COUNTY PHARMACY BENEFIT PLAN

ADMINISTRATIVE INFORMATION

Plan Name:	Maricopa County Pharmacy Benefit Plan
Plan Sponsor:	Maricopa County
Group Number:	512229
Type of Plan:	Pharmacy Benefit Plan
Plan Administrator:	Walgreens Health Initiatives (WHI)
Address: (Pharmacy Benefit Manager)	2275 Half Day Road, Suite 250 Bannockburn, IL 60015
Funding Mechanism:	Self-Insured
Plan Year:	Jan. 1 to Dec. 31

ABOUT THIS DOCUMENT

- This Summary Plan Document (SPD) is intended to describe your pharmacy benefit plan. Every effort has been made to ensure the information contained in this SPD is accurate. If there is a discrepancy in the information, the plan sponsor will make the final determination.
- The plan sponsor reserves the right to amend or terminate any benefit described in this document at any time. Notices of changes will be communicated through the Electronic Business Center (EBC), Maricopa County's Intranet.
- The plan and/or WHI has the right to deny benefits for any drug prescribed or dispensed in a manner that does not conform to normal medical or pharmaceutical practices or that are received in a manner that does not conform to the plan design.
- When the words "we," "us," "our," and "plan" are used in this document, they refer to Maricopa County. When the words "you" and "your" are used, they refer to the Maricopa County employees, retirees and COBRA participants who are covered for medical care through certain CIGNA medical products (CIGNA Health Maintenance Organization, Point Of Service and Preferred Provider Organization).
- The Maricopa County Employee Benefits Office has two Web sites for employee use. The address of the Internet site is http://www.maricopa.gov/benefits, and the EBC/Intranet site is located at http://ebc.maricopa.gov/hr/benefits. Both of these Web sites are collectively referred to as the "Benefits Home Page" in this document.

INTRODUCTION AND DESCRIPTION OF BENEFITS

This SPD explains your pharmacy benefits, how you are able to access these benefits and limitations and exclusions that apply. This document and the pharmacy benefit plan are effective Jan. 1, 2005.

There are two pharmacy benefits from which to choose: the Coinsurance Rx benefit or the Consumer Choice Rx benefit.

COINSURANCE RX BENEFIT

The Coinsurance Rx benefit is a multi-level plan in which a coinsurance amount (percentage of the cost of the medication) is charged (unless the applicable minimum or maximum threshold is met) based on the classification of the medication. This plan covers all generic, preferred brand name and non-preferred brand name medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications, and some drug classes, such as infertility and cosmetic medications, are excluded.

Tier One covers generic medications. Tier Two covers brand name medications that are on the preferred medication list (PML) (an approved list of generic and brand name preferred drugs). Tiers Three and Four cover brand name medications that are not on the PML. Each tier has minimum amounts. Tiers One and Two have maximum amounts you will pay for a medication on that tier. Each tier also has coinsurance – a percentage of the cost of the medication. You will be charged the minimum, the maximum or the coinsurance amount for the medication based on the medication's tier and cost.

Most generic medication is listed on the WHI PML. Because so many generic medications are available, only the most frequently used generics are listed. However, all generics are covered. Generic medications are listed in lowercase on the PML.

Preferred brand name medications are also listed on the WHI PML in uppercase.

Non-preferred brand name medications are not listed on the WHI PML. These are brand name medications that are covered at a higher out-of-pocket cost.

The coinsurance you pay toward any covered medication will be applied to your maximum out-of-pocket limit. The maximum out-of-pocket limit is $1,500 for an individual and $3,000 for a family. Once the out-of-pocket limit is met, covered medications are paid 100 percent by the plan for the remainder of the year. Any covered member's coinsurance contributes to the family out-of-pocket maximum.

As mentioned above, the Coinsurance Rx benefit uses a PML, created and maintained by WHI, the plan administrator. The formulary is a tool that guides you and your physician, when selecting medications, toward drugs that maximize your benefit.

The drugs on the PML and drugs newly approved by the U.S. Food and Drug Administration (FDA) are reviewed periodically by WHI's Pharmacy and Therapeutics Committee. The committee is comprised of physicians and pharmacists who are tasked with objectively evaluating drugs for therapeutic treatment, safety and cost-effectiveness in order to determine placement on the PML.

The WHI Preferred Medication List is mailed to newly enrolled participants shortly after enrollment along with an identification (ID) card and a registration form for mail order service. The guide is also available via the Internet at WHI's Web site, www.mywhi.com. Please note that the PML is a listing of the drugs that are most commonly prescribed. Other drugs, especially generics, may be covered. Conversely, since the WHI PML is used for many of WHI's other clients, **not all drugs listed in the PML are covered under your pharmacy plan. Your pharmacy benefit plan has certain exclusions and limits that apply.** Please refer to the "Exclusions and Limitations" section of this document for more information.

The brand name of a drug is the product name under which it is advertised and sold. By law, generic drugs must have the same FDA standards for quality, strength and purity as their brand name counterparts. Since the coinsurance for generic drugs is lower, ask your physician about prescribing generic drugs. The pharmacist may ask your physician whether a generic drug might be appropriate; however, your physician makes the final decision.

If your medical coverage is through the CIGNA HealthCare for Seniors group Medicare + Choice plan, then your pharmacy benefit is available through CIGNA.

Coinsurance Rx Benefit Schedule of Costs

Retail 30- or 84-91-Day Supply

- **Generics (on the PML):** You are responsible for 25 percent of the contracted cost.* The cost of each prescription will be at least $2 but no more than $12 for a 30-day supply or at least $6 but no more than $36 for a three month (84-91-day) supply.
- **Preferred brand name medications (on the PML):** You are responsible for 30 percent of the contracted cost.* The cost of each prescription will be at least $5 but no more than $30 for a 30-day supply or at least $15 but no more than $45 for an 84-91-day supply.
- **Non-preferred brand name medications (not on the PML) with a generic equivalent:** You are responsible for 50 percent of the contracted cost* plus the difference between the cost of the generic medication and the brand name medication. The cost of each prescription will be at least $20 for a 30-day supply or at least $60 for an 84-91-day supply. There are no maximum amounts for the costs of medications in this category.
- **Non-preferred brand name medications (not on the PML) with no generic equivalent:** You are responsible for 50 percent of the contracted cost.* The cost of each prescription will be at least $20 for a 30-day supply or at least $60 for an 84-91-day supply. There are no maximum amounts for the costs of medications in this category.
- **Specialty pharmacy medications (not on the PML):** You are responsible for a $50 copayment for a 30-day supply of specialty medications for complex health conditions. Specialty medications are received through the specialty pharmacy program, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient conditions requiring the use of specialty medications include, but are not limited to, acromegaly, chronic granulomatous disease, cystic fibrosis, gaucher disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis.

Mail Order 84-91-Day Supply

- **Generics (on the PML):** You are responsible for 15 percent of the contract cost.* The cost of each 84-91-day prescription will be at least $6 but no more than $28.
- **Preferred brand name medication (on the PML):** You are responsible for 25 percent of the contract cost.* The cost of each 84-91-day prescription will be at least $15 but no more than $70.
- **Non-preferred brand name medication (not on the PML) with generic equivalent:** You are

responsible for 50 percent of the contract cost* plus the difference between the cost of the generic and brand medications. The cost of each 84-91-day prescription will be at least $60. There are no maximum amounts for the cost of medications in this category.

- **Non-preferred brand name medication (not on the PML) without a generic equivalent:** You are responsible for 50 percent of the contract cost.* The cost of each 84-91-day prescription will be at least $60. There are no maximum amounts for the cost of medications in this category.
- **Specialty pharmacy medications (not on the PML) and received through home delivery**: You are responsible for $50 for a 30-day supply.

**Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.*

NOTE: IF YOU HAVE CIGNA AS YOUR MEDICAL INSURANCE, THEN DIABETIC SUPPLIES AND MEDICATIONS MAY BE OBTAINED AT A CIGNA MEDICAL GROUP FACILITY FOR $10 PER ITEM. IF YOU HAVE HEALTHSELECT AS YOUR MEDICAL INSURANCE, THEN DIABETIC SUPPLIES MAY BE OBTAINED THROUGH WALGREENS HOME CARE FOR A $0 COPAYMENT.

CONSUMER CHOICE RX BENEFIT

The Consumer Choice Rx benefit is a multi-level plan in which Maricopa County fully funds the first level (pharmacy account), you fund the second level (deductible), and you and Maricopa County share the cost of the third level (insurance) through coinsurance. Any unused portion of the pharmacy account is rolled over to the next benefit year, creating a credit balance that you can use to pay for future prescriptions.

The benefit is geared towards smart spending of all funds through the use of the most cost-effective medication. No preferred medication list (PML) is used to manage this benefit because much of the management of this benefit is up to you. Some medications require prior authorization. Certain medications that could be used in a cost-effective order (step therapy) have messages advising the pharmacist to alert you if you've chosen a more expensive medication when a more cost-effective medication is available. You may also receive a letter in the mail advising you of a less expensive alternative to your current medication. Quantity limits apply for certain medications, and some drug classes, such as infertility and cosmetic medications, are excluded.

The amounts you pay toward any covered medication will be applied to your maximum out-of-pocket limit. The maximum out-of-pocket limit is $1,500 for an individual and $3,000 for a family. Once the out-of-pocket maximum is met, covered prescriptions are paid 100 percent by the plan for the remainder of the year. Any covered member's coinsurance contributes to the family out-of-pocket maximum.

- **Pharmacy Account:** The account is funded 100 percent by Maricopa County at the rate of $200 per individual or $400 per family as a credit balance. You use this credit to pay for prescription medications at the contracted cost.* Any unused credit is rolled over to the next benefit year.
- **Deductible (Employee Responsibility):** The deductible is funded 100 percent by you at the rate of $200 per individual or $400 per family. You spend your deductible amount toward your prescription medications at the contracted costs.* If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to be reimbursed for medication costs at this level.
- **Insurance:** The insurance level covers the cost of the medication at 80 percent of the contracted cost * of the medication. You pay 20 percent of the contracted cost.* If you have enrolled in the Mariflex flexible spending account, you can use your pre-taxed funds to be reimbursed for medication costs at this level.
- **Specialty pharmacy medications:** These medications will not be charged against your pharmacy account or deductible. Instead, a $50 copay will be charged for each prescription. The copays will be applied toward the out-of-pocket maximums. Specialty medications are received

through the specialty pharmacy program for complex health conditions, with an emphasis on expensive and difficult-to-find medications, injectables or other medications involving complex administration methods, strict compliance requirements, special storage, handling and delivery, education, monitoring and ongoing patient support. Patient conditions requiring the use of specialty medications include, but are not limited to, acromegaly, chronic granulomatous disease, cystic fibrosis, Gaucher's disease, hemophilia, multiple sclerosis, HIV/AIDS, viral hepatitis, some oncology-related conditions, psoriasis, rheumatoid arthritis, growth hormone disorders, respiratory syncytial virus (RSV), solid organ transplant and deep vein thrombosis.

**Contracted cost is the discounted average wholesale price of the prescription plus the dispensing fee.*

UNDERSTANDING WHAT IS COVERED

To understand your pharmacy benefit, please read the "Introduction and Description of Benefits" section.

UNDERSTANDING WHAT IS NOT COVERED

To understand what is not covered under your pharmacy benefit, please read the section entitled "Exclusions and Limitations" for a listing of what is not covered under the pharmacy benefit plan. For specific drug categories that are not covered, refer to the "Introduction and Description of Benefits" section.

YOUR FINANCIAL RESPONSIBILITY

For the Coinsurance Rx benefit and for the insurance level of the Consumer Choice Rx benefit, your pharmacy benefit charges you a percentage of the discounted average wholesale price (AWP) of the drug plus the dispensing fee. This percentage charge is referred to as coinsurance. Coinsurance is your responsibility and must be paid directly to the pharmacy at the time your prescription is filled. Minimum and maximum amounts may apply to your charges.

OBTAINING PHARMACY BENEFITS

OBTAINING COVERED PRESCRIPTIONS

You can obtain your prescriptions from three different sources, depending on your needs. The three sources include a retail pharmacy within the WHI national network for a 30-day supply, a WHI Advantage 90 retail pharmacy (Walgreens, Osco, Albertsons or CVS) for an 84-91-day supply, and mail order through Walgreens Healthcare Plus for an 84-91-day supply. All three sources have contracted pharmacies within the WHI network. Prescriptions filled at non-contracted pharmacies are not covered under your pharmacy benefit plan. An exception to obtaining prescriptions at non-contracted pharmacies exists if you are obtaining diabetic medications or supplies. Medications and supplies specific to the treatment of diabetes may be obtained through a CIGNA Medical Group (CMG) facility pharmacy if you are covered by CIGNA for your medical insurance.

Medication may be obtained for up to a 30-day supply, or for an 84-91-daysupply. **Medication obtained in a 31-83-day quantity or greater than a 91-day quantity will not be covered under your benefit.**

Federal law prohibits the return of dispensed prescription medication. It is advisable to check your medication before leaving the pharmacy to make sure you are charged correctly and that you received the correct number of pills.

SHORT-TERM NEEDS

UP TO A 30-DAY SUPPLY AT RETAIL PHARMACIES

WHI's retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or monthly. You can choose from thousands of participating network pharmacies nationwide, and you can obtain up to a 30-day supply at one time. You can find the nearest participating network pharmacy by calling **WHI's Member Services** at **800-207-2568** or by going on-line via the Internet to www.mywhi.com. A small number of medications are limited to a 30-day or less supply, such as, but not limited to, Accutane and Peg-Intron.

LONG-TERM NEEDS

THREE MONTH SUPPLY AT CERTAIN RETAIL STORES (PHARMACIES)

When you need prescriptions for chronic or long-term health conditions (such as high blood pressure, diabetes or asthma), you can purchase a three-month supply at any pharmacy located in a Walgreens, Osco, Albertsons or CVS retail store. The physician must write your prescription for an 84-91-day supply. If you are a HealthSelect member and your prescription is written by a CHC or FHC physician, you can receive a three-month supply at any of the MIHS pharmacies located in the CHC or FHCs.

THREE MONTH SUPPLY THROUGH THE MAIL ORDER PHARMACY

Prescriptions for maintenance medications or long-term health conditions can also be ordered through the Walgreens Mail Service pharmacy. Ordering through the mail is both a safe and convenient way to receive prescriptions and save money. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan identification information. This form is called the **Tempe Registration and Order Form** and is available online at the Benefits Home Page or at WHI's Web site: www.mywhi.com. You can even register online at the WHI Web site instead of completing a hard copy of the form. **Forms are not available through Walgreens Customer Service.**

Send the completed form, along with your original written prescription, to **Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038**. Be sure to include your group number, **512229**, on the form. You may pay by check, money order, VISA, MasterCard, Discover and American Express. Please do not send your debit card number or cash.

Your doctor cannot phone in new prescriptions. However, your doctor may send a new prescription via facsimile (fax). The required form is called the **Tempe Physician Fax Order Form** and is available at www.mywhi.com or by selecting the Member Forms link or the WHI link on the Benefits Home Page.

When your order is filled, it will be promptly delivered via U.S. mail. Your package usually arrives within seven to10 days. Your order will include medication container(s), instructions for refills and information about your medication.

To ensure that you don't run out of medication, remember to reorder on or after the refill date indicated on your refill slip or medication container, or when you have 14 days of medication left.

DRUG UTILIZATION ALERTS AT TIME OF PURCHASE

Drug Utilization Review (DUR) is an effective tool used by WHI in monitoring your drug use to assure that it is appropriate, safe and effective. At the time of purchase, WHI's DUR program monitors your claim submissions across all pharmacies and prescribing physicians, compares each claim with your active prescriptions and notifies the pharmacists if any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) guidelines and monitors every prescription for numerous conditions. The pharmacist may decide not to dispense medication based on the DUR alert received at the point of service. Examples of some of the DUR alerts are listed below.

DRUG/DRUG INTERACTION

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more medications at the same time. The possible results of the interaction could include an increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these interactions occur, the WHI system advises the dispensing pharmacist that the drug he/she is about to dispense may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgment to intervene, if necessary, to prevent the patient from being harmed.

OVERUTILIZATION

The submission of prescription drug claims across all contracted pharmacies is monitored. When a prescription claim request is received, the WHI system reviews the patient's drug profile, searching for a previous prescription for the same drug or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim if the request for the medication is being submitted sooner than the plan recognizes as appropriate.

THERAPEUTIC DUPLICATION MONITORING

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed drug may duplicate the therapeutic effects of another drug already prescribed for the patient. This duplication can occur even when the two drugs are prescribed for different medical conditions.

When a duplication of therapy is detected, WHI transmits this information to the dispensing pharmacist, including the name of the drug that is duplicating the therapy, for further evaluation and intervention.

RETROSPECTIVE DRUG UTILIZATION REVIEW

WHI reviews all prescriptions after they are purchased to assist your health care providers in their effort to ensure safe and appropriate use of medications for you. As part of this program, WHI pharmacists may confidentially analyze your medication history in order to determine appropriateness of therapy. The prescribing doctor may be provided with the most recent educational materials based on nationally accepted therapy guidelines to assist in this determination.

MAXIMUM OUT-OF-POCKET LIMIT

The coinsurance or copay, including minimum and maximum amounts, paid towards any covered drug will be applied to your maximum out-of-pocket limit. The maximum out-of-pocket limit is the most you will pay for covered prescription drugs during a calendar year.

- The maximum out-of-pocket limit for individual coverage is $1,500.
- The maximum out-of-pocket limit for family coverage is $3,000.

Once you and/or your covered dependents meet the out-of-pocket maximum, covered prescriptions are paid 100 percent by the plan for the remainder of the calendar year. Any number of family members can contribute to the family out-of-pocket maximum. The amount you pay for any *non-covered drug* will not be included in calculating your annual out-of-pocket maximum. You are responsible for paying 100 percent of the cost for any non-covered drug.

Note: Diabetic supplies and medications obtained at a CIGNA Medical Group facility under your medical insurance are not included in your maximum out-of-pocket limit.

COVERED ITEMS

The following items are covered under the pharmacy benefit plan, unless specifically listed in the “Exclusions and Limitations” section.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications and supplies such as blood glucose monitors, test strips, disposable insulin syringes, lancets (including automatic lancing devices), glucagon, prescribed oral agents for controlling blood sugar and any of the devices listed above that are needed due to being visually impaired or legally blind.

  Note: Insulin pumps and cartridges are available through your medical insurance durable medical equipment (DME) provider.

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including, but not limited to, certain anti-fungals, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles.
- Fertility drugs (oral and injectable).
- Diabetic urine tests, alcohol swabs.
- Nutritional/dietary supplements.

  Note: Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your medical insurance according to Arizona state statute.
- Over-the-counter medications and other over-the-counter items.
- Injectables obtainable through and administered by a physician in an office setting. If the medication is available and administered through your physician's office, then it may be covered through your medical insurance in-network plan.
- Miscellaneous medical supplies.
- Coverage of prescription drug products for an amount that exceeds the supply limit (either days supply or quantity limit).
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws.
- Charges to administer or inject any drug.
- Certain self-injectable drugs.
- Prescription drugs not medically necessary.
- Charges for delivering any drugs except through the mail order benefit. Express or overnight delivery costs are not covered.
- Experimental or investigational medications.
- Prescription drugs purchased from an institutional pharmacy for use while you are an in-patient of that institution (hospital, skilled nursing facility or alternate facility), regardless of the level of care.
- Prescription drugs furnished by the local, state or federal government.
- A specialty medication prescription drug product (such as immunizations and allergy serum) which, due to its characteristics as determined by the plan administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
- Replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill.
- Prescription drug products for smoking cessation, unless they are provided through an approved wellness program through Maricopa County.

Note: Reimbursement for prescription drugs you purchased at full retail cost is subject to review under the direct member reimbursement process. Reimbursement is limited to the contract cost less coinsurance or copay. Refer to the "Direct Member Reimbursement" section.

PREFERRED MEDICATION LIST MANAGEMENT

A PML is a list of medications that have received FDA approval as safe and effective, and have been chosen for inclusion on the PML by a committee of physicians and pharmacists. The PML can help you and your physician maximize your pharmacy benefits while minimizing overall prescription drug costs to you *and* the plan sponsor.

WHI's Pharmacy and Therapeutics (P&T) committee evaluates clinical efficacy and safety of each drug and votes the drug into one of three categories:

- **Therapeutically Unique** – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile, prompting automatic addition to the PML.
- **Therapeutically Equivalent** – Clinical effectiveness and safety profile are comparable to existing drugs.
- **Therapeutically Inferior** – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable, prompting automatic non-PML status.

Products classified by the P&T committee as therapeutically equivalent are then further evaluated from an economic perspective to determine which clinically appropriate drugs are most cost-effective for clients. The P&T committee's evaluation is based solely on clinical criteria. Only after the P&T committee's clinical assessment is made are the economics of the drug considered.

New FDA-approved drugs that arrive on the market are automatically available to you and are initially classified as non-preferred, except those excluded under your benefit plan. Based on the P&T committee's decision, the new drug may then be classified as a preferred medication. Additions to the PML may be made on a quarterly basis throughout the year, with deletions most often occurring annually.

The most up-to-date PML is available on the WHI Web site at www.mywhi.com.

Note: Drugs that are listed on the PML may not be covered as they are subject to Maricopa County's specific plan coverages, exclusions and limitations.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization (approval from the plan before they will be covered). Types of prior authorizations include, but are not limited to, medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe, where an age limitation has been reached and/or exceeded or where appropriate utilization must be determined. WHI, in its capacity as pharmacy benefit manager, administers the clinical prior authorization process on behalf of Maricopa County.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the physician, you or your covered dependents by calling 1-877-665-6609 Monday through Friday, 8 a.m.-8 p.m., Central Standard Time (CST). The pharmacy *may* call after being prompted by a medication denial with a message stating, "*Prior authorization required; call 1-877-665-6609."* The pharmacy may also pass the information on to you and require you to request the prior authorization.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that Maricopa County participates in a CPA program for the particular drug category. The Clinical Services Representative generates a drug-specific form and faxes it to the prescribing physician. Once the fax form is received from the physician by the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from WHI's receipt of the completed form from the prescribing physician, not including weekends and holidays.

If the prior authorization request is approved, the WHI Clinical Services Representative calls the person who initiated the request and enters an override into the WHI processing system for a limited period of time. The pharmacy will then process the prescription.

If the prior authorization request is denied, the WHI Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the reason for denial. The letter will include instructions for appealing the denial. For more information, see the "Appeal Procedures" section.

Drug categories or medications that require prior authorization include, but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy
- Anabolic steroids (all forms)
- Insomnia
- Anti-obesity
- Anti-fungals (i.e., Lamisil, Sporanox and Diflucan)
- Migraine medications (all forms of treatment)
- Leukotrienes (e.g., Singulair)
- Botulinum Toxins (e.g. Botox)
- Growth Hormone

The criteria for the CPA program are based on nationally recognized guidelines, FDA-approved indications and accepted standards of practice. Each guideline has been reviewed and approved by WHI's P&T committee for appropriateness.

To confirm whether you need prior authorization and/or to request a prior authorization, call **WHI's Clinical Member Services at 877-665-6609** Monday through Friday, 8 a.m.-8p.m., CST. Please have the information listed below available when initiating your request for prior authorization:

- Name of Your Medication
- Prescribing Physician's Name
- Prescribing Physician's Phone Number
- Prescribing Physician's Fax Number, if available
- WHI Member ID Number (from your WHI ID card)
- Maricopa County Group Number: **512229**

In some instances, the Coinsurance Rx benefit may require that a therapeutically equivalent prerequisite medication be tried before other medication is approved. This is called step therapy.

Drug categories or medications that require step therapy include, but are not limited to:

- Proton Pump Inhibitors (PPIs such as Prilosec, Prevacid, Nexium, Protonix and Aciphex)
- Cox II inhibitors (i.e., Celebrex and Bextra)

AGE AND QUANTITY LIMITATIONS

Some medications are subject to age and quantity limits. Your claim will be denied at the time of purchase if it exceeds these limitations. Limitations are based on criteria developed with guidelines from various national medical agencies in conjunction with WHI's clinical review process.

AGE LIMITATIONS

Certain medications have an ***age*** limitation, including, but not limited to, the following health conditions:

- Topical Acne
- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy

If your prescription is denied due to age limitations, but you and your physician believe that it is medically necessary for you to take this medication to treat one of the above conditions, you may request prior authorization. Refer to the "Prior Authorizations" section for details.

QUANTITY LIMITATIONS

Certain medications have ***quantity*** limitations, including, but not limited to, the following health conditions and medications:

- Impotency*
- Insomnia
- Migraine Medications
- Stadol
- Diflucan

*__Note__: Impotency limitation is a set monthly quantity. The limitation for this condition is not appealable. Prior authorization does not apply.

If your prescription is denied due to quantity limitations and you and your physician believe that it is medically necessary for you to take a larger quantity of this medication, you may request prior authorization. Refer to the "Prior Authorizations" section for details.

SPECIALTY PHARMACY PROGRAM

Certain medications used for treating chronic or complex health conditions are handled through the WHI Specialty Pharmacy Program.

The purpose of the Specialty Pharmacy Program is to assist you with monitoring your medication needs for conditions such as those listed below and to provide patient education. The program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage handling and delivery.

Medications covered through the Specialty Pharmacy Program may include, but are not limited to, the following conditions:

- Cystic Fibrosis
- Multiple Sclerosis
- Viral Hepatitis
- Growth Hormone Deficiency
- Hemophilia
- HIV/AIDS

Medications through the Specialty Pharmacy Program may be obtained only in 30-day increments through a retail Walgreens store or through Walgreens Healthcare Plus home delivery service.

Note: Walgreens home delivery service is similar to Walgreens Mail Service pharmacy. The difference is that Walgreens home delivery service allows for 30-day increments in the Specialty Pharmacy Program.

You may enroll in the Specialty Pharmacy Program by contacting **WHI's Specialty Care Pharmacy Center** at **1-888-782-8443**, or a Specialty Care Representative may contact you to facilitate your ongoing prescription needs. Trained Specialty Care pharmacy staff is available 24 hours a day, seven days a week to assist you.

ELIGIBILITY REQUIREMENTS

If you are an active employee, retiree or have elected COBRA and are enrolled in a CIGNA or HealthSelect medical plan, this pharmacy benefit plan applies to you.

If your medical coverage is through the CIGNA HealthCare for Seniors Group Medicare plus Choice plan, your pharmacy benefit is available through CIGNA HealthCare of Arizona.

TERMINATION

Coverage ends the last day of the payroll period in which you cease to be eligible for coverage or for which a premium was paid, whichever comes first. Please refer to "When Does Coverage End?" and "Do Benefits Continue While on a Leave of Absence?" sections of the *Know Your Benefits* guide for details.

EXCEPTIONS

- Dependent spouse and stepchildren coverage ends on the date of divorce.
- Dependent child coverage ends on the date the child loses dependent status due to reaching an age limitation, ending attendance in an institution of higher education, marriage, changing to a different residence than yours, ending of a support order or changing of support requirements (i.e., no longer primarily dependent upon you for more than 50 percent of his/her support).

You are responsible for immediately notifying the Benefits Office when a dependent no longer meets the eligibility requirements listed in the "Are Dependents Covered?" section of the *Know Your Benefits* guide. Prescription and administrative costs paid or incurred on behalf of an ineligible dependent become your responsibility.

When any of the following happen, we will provide you written notice that coverage has ended on the date we identify in the notice.

- **Fraud, Misrepresentation or False Material Information**: You provided false information related to another person's eligibility or status as a dependent.
- **Improper Use of ID Card**: You permitted an uncovered person to use your ID card.
- **Failure to Pay**: You failed to pay the required premium for coverage.
- **Threatening Behavior**: You commit an act of physical or verbal abuse that poses a threat to administrative or clinical personnel associated with the management of this plan.

RIGHT OF RECOVERY

If the amount of payment we made is more than we should have paid, we may recover the excess from you or from one or more of the persons we paid. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

IDENTIFICATION CARDS

WHI issues ID cards to you for identification purposes only. The ID card is not proof of coverage or of eligibility for services on a particular date of service.

You should show your ID card at the time you obtain your prescription drug product at a contracted (participating) pharmacy or provide the pharmacy with identifying information that can be verified with the Benefits Office during regular business hours.

The computer system at the pharmacy will confirm your eligibility for benefits even if you do not have your WHI ID card with you, as long as you provide the pharmacist with the following information:

- RxBIN 603286
- RxPCN 01410000
- RxGrp 512229
- Issuer (80840)
- Your name
- Your WHI ID number (either your Employee ID Number or your Alternative ID Number)

If you don't show your ID card or provide verifiable information, you will be required to pay for the prescription product at the pharmacy. Our contracted pharmacy reimbursement rates (our prescription drug cost) will not be available to you.

You may receive reimbursement from us as described in the "Direct Member Reimbursement" section. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the prescription drug product was dispensed. The amount you are reimbursed will be based on the contracted reimbursement rate, less the required coinsurance or copay.

To be entitled to the covered prescription medication, you must be the employee or a covered dependent on whose behalf all applicable premiums have been paid, and all eligibility requirements have been met. Any person receiving a covered prescription medication who is not entitled, including, but not limited to, fraudulent information submitted to WHI, will be fully responsible for reimbursement of the covered prescription medication.

If you lose your ID card or need additional cards for covered dependents, call **WHI Member Services** at **800-207-2568** and provide your name and ID number. Your ID number is your Social Security Number, your Employee ID Number or an Alternative Identification Number. Two additional cards will be sent to your address on file with Maricopa County's Human Capital System. Please note that only the employee's name is listed on the ID card. However, your eligible and enrolled dependents may access their pharmacy benefit by using your ID card.

DIRECT MEMBER REIMBURSEMENT

There may be instances where you are in need of a prescription for which you are eligible but are unable to have your claim processed through a WHI pharmacy due to situations such as being outside the service area, an emergency or being a new member whose enrollment has not been processed. In situations such as these, you will be required to pay the full retail cost of the covered medication.

You can receive reimbursement for covered prescriptions you've paid for under the plan by following these steps:

1. Pay the pharmacist the full amount of your prescription. Keep your prescription receipt(s).
2. Obtain and complete a Direct Member Reimbursement (DMR) claim form available via the Benefits Home Page.
3. Send your completed form and itemized receipts to the Benefits Office at 301 W. Jefferson, Suite 201, Phoenix, AZ 85003. DMR requests must be received at the Benefits Office within six months from the date of service in order to be eligible for reimbursement.

The Benefits Office will make a determination and, if approved, will forward your claims to WHI to process your request for reimbursement according to the plan's guidelines, coverages and limitations. If the request is approved, you should receive your reimbursement within four weeks.

Please note that WHI will reimburse you according to the plan's guidelines. You will receive the contracted amount for the medication less your coinsurance instead of the full retail price of the medication, unless there was an administrative error on the part of the Benefits Office.

APPEAL PROCEDURES

If you are dissatisfied with the service received under this pharmacy benefit, you are encouraged to contact **WHI's Member Services Department 24 hours a day, seven days a week at 1-800-207-2568**. Frequently, your concern can be resolved with a telephone call to a Member Services Representative. If WHI Member Services cannot resolve your concern, you may proceed to the Maricopa County Appeal Procedures as set forth below. Examples of concerns for which you may file an appeal include, but are not limited to, quality of service received, denial of a CPA of a drug, payment amount or denial of a claim. Please note that denials of a CPA due to medical information not being received by WHI from your physician will not be considered for the appeal process. Please note that plan design and PML content are not issues that can be appealed.

MARICOPA COUNTY'S APPEAL PROCEDURE

You may file an appeal in writing by completing the **Pharmacy Program Appeal Form** that is available on the Benefits Home Page. You may submit this form in person or by mail to a Benefits representative located in the Maricopa County Employee Benefits Office at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, Monday through Friday 8 a.m.–5 p.m. You will be notified of receipt of the appeal within five business days.

If the appeal is non-medical in nature, you will receive a response from the Maricopa County Benefits Office. Turnaround time for non-medical concerns is 30 calendar days from the date the Benefits Office receives the appeal. If additional research is required to resolve your appeal, you will receive a written progress report prior to the 30th day and at 30-day intervals until a determination is rendered.

If the appeal is regarding a denial of a CPA or other clinical issue, an independent review organization (IRO) contracted by WHI will provide you with the resolution.

For denied CPA appeals, the plan sponsor will track and forward the appeal form and medical necessity documentation that you submit from the prescribing physician to WHI's Clinical Call Center. WHI will forward the appeal request to the IRO for review. The IRO assigns an independent physician to review your issue based on the case. The IRO physician will review the appeal and make a recommendation. The IRO submits its recommendation to WHI's Clinical Call Center, which notifies you by mail of the resolution, with a copy to the plan sponsor. The turnaround time for a CPA appeal is five business days from the date the appeal is received by the IRO, excluding holidays and weekends.

If the appeal is regarding a clinical issue such as prospective reviews, quality of care, retrospective reviews or other types of appeal requests that are not classified as a CPA, the appeal follows the same process as above, with a turnaround time of five to 15 business days from the date the IRO received your information, excluding holidays and weekends.

WHI NATIONAL NETWORK

You can choose from more than 54,000 contracted pharmacies. Below are some of the many pharmacies participating in the WHI nationwide 30-day retail network. For additional participating pharmacies, call **WHI's Member Services at 800-207-2568** 24 hours a day, seven days a week or visit the WHI Web site at www.mywhi.com.

- Albertsons Pharmacy
- CIGNA CMGs
- Costco Pharmacy
- CVS
- FHCs & CHC
- Fry's Pharmacy
- Kmart
- Osco
- Safeway Pharmacy
- Sam's Club
- Target
- Thrifty Drug
- United
- Walgreens
- Wal-Mart

IMPORTANT PHONE NUMBERS

NAME	PHONE	HOURS	WHO	REASONS TO CALL *(Including but not limited to)*
WHI Member Services	800-207-2568 Toll free	24 hours a day, 7 days a week	• Members • Dependents • Pharmacies • Maricopa County benefits personnel	• Eligibility • Prescription will not process • Find out if a drug is covered • Find out if drug is on PML • Find out your coinsurance
WHI Clinical Call Center	877-665-6609 Toll free	Monday – Friday, 8 a.m.–8 p.m. (Central Standard Time)	• Members • Dependents • Pharmacies • Physicians • Maricopa County benefits personnel	• Initiate a clinical prior authorization (CPA) review • Check status of a CPA review • Check to see if prior authorization is required for a drug *(See PRIOR AUTHORIZATIONS section for details.)*
WHI Specialty Pharmacy Center	888-782-8443 Toll free	Monday – Friday, 8 a.m.–10 p.m. (Eastern Standard Time)	• Members • Dependents • Physicians	• Obtain a specialty medication • Check on status of a specialty drug (See *SPECIALTY PHARMACY PROGRAM* section for details.)
Walgreens Healthcare Plus Mail Service Pharmacy	888-265-1953 Toll free	Monday – Friday, 7 a.m.–7 p.m. Saturday, 7 a.m.–Noon (Mountain Standard Time)	• Members • Dependents	• Check on status of a mail order prescription
Maricopa County Employee Benefits Office	602-506-1010	Monday – Friday, 8 a.m.–5 p.m. (Mountain Standard Time)	• Maricopa County employees	• Eligibility • File an appeal (See *APPEAL PROCEDURES* section for details.) • Reimbursement for prescriptions for which you paid (See *DIRECT MEMBER REIMBURSEMENT* section for details.)